

## 516 CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <b>Maryland</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>unknown</u>	
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>W.</u> Last <u>ARO</u>		4. DATE OF DEATH Month <u>January</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6-27-87</u>
9. AGE (In years last birthday) <u>71</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Caretaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel W. Aro - Deceased</u>		14. MOTHER'S MAIDEN NAME <u>Mary Flahart - Deceased</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>216-12-3328</u> <u>unknown</u>	
17. INFORMANT <u>Hospital Records, VAH, Perry Point, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Emphysema</u> 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 5, 1959</u> , to <u>January 7, 1959</u> and that death occurred at <u>8:50 PM</u> , from the causes and on the date stated above. <u>XXXXXXXXXXXXXXXXXXXX</u> ADDRESS (Street, city or town, state) DATE SIGNED <u>M. Harris</u> M.D. <u>V.A. Hospital, Perry Point, Md.</u> <u>1-7-59</u>			
ACTUAL SIGNATURE		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>W. M. HARRIS</u>		Acting Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 10, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gilpin Manor Mem. Park</u>	22d. LOCATION (City, town, or county) (State) <u>Nr. Elkton, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald H. Free</u> ADDRESS <u>H.W. PIPPIN &amp; SON, Elkton, Maryland</u>		24a. REC'D BY REGISTRAR <u>MAN 9 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00505

Reg. Dist. No.

517

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit, R.D.</u>		c. LENGTH OF STAY IN 1b <u>All life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit R.D.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>B</u> Last <u>Astle</u>			4. DATE OF DEATH Month <u>1</u> Day <u>5</u> Year <u>1959</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>L-1 1888</u>		9. AGE (In years last birthday) <u>71</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John Wesley Astle</u>			14. MOTHER'S MAIDEN NAME <u>Annie C. Chandlee</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-36-5942</u>		17. INFORMANT Address <u>Mrs. Helen Astle, Port Deposit, Md. R.D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>R. C. Dodson</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>R. C. Dodson</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-9-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rosebank</u>	
22d. LOCATION (City, town, or county) <u>Colvert, Cecil Co. Md.</u>		22e. (State) <u>Md.</u>		22f. (City or town) (County) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant North East Md</u>		24a. REC'D BY REGISTRAR <u>JAN 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Grant</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED	
RESIDENCE	
DATE OF DEATH	
PLACE OF DEATH	
CAUSE OF DEATH	
MANNER OF DEATH	
SIGNATURE OF MEDICAL EXAMINER	
OFFICE OF MEDICAL EXAMINER	
DATE OF EXAMINATION	
PLACE OF EXAMINATION	
SIGNATURE OF WITNESS	
OFFICE OF WITNESS	
DATE OF WITNESSING	
PLACE OF WITNESSING	

518

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point,</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>13yrs1mo.18days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>451 Oxford Court</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>J.</b> Last <b>BAILEY</b>		4. DATE OF DEATH Month <b>January</b> Day <b>11</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 23, 1889</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Elijah Bailey</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Nixon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or if unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital Records, VA Hospital, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral, lower lobes</b> DUE TO <b>unresolved</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pyelonephritis, right kidney organism unknown</b> DUE TO <b>unknown</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic heart disease - unknown</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 24,</b> 19 <b>45,</b> to <b>January 11,</b> 19 <b>59</b> , and that death occurred at <b>6:00 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>S. P. LACERVA</b> M.D. <b>V.A. Hospital, Perry Point, Md. 1-12-59</b>			
PHYSICIAN'S NAME (Type) <b>S. P. LACERVA</b>		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>1/13/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Havre DeGrace, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 20 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

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1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Signature of physician

8. Signature of registrar

9. Signature of medical examiner

10. Date of burial

11. Place of burial

12. Name of cemetery

13. Name of funeral home

14. Name of undertaker

15. Name of family

16. Name of next of kin

17. Name of executor

18. Name of administrator

19. Name of witness

20. Name of witness

21. Name of witness

22. Name of witness

23. Name of witness

24. Name of witness

25. Name of witness

26. Name of witness

27. Name of witness

28. Name of witness

29. Name of witness

30. Name of witness

31. Name of witness

32. Name of witness

33. Name of witness

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35. Name of witness

36. Name of witness

37. Name of witness

38. Name of witness

39. Name of witness

40. Name of witness

511  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS 306 Landing Lane			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Louisa CONREY				4. DATE OF DEATH January 23, 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 22, 1877	
				9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William A. Queck				14. MOTHER'S MAIDEN NAME Susan Godshall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO. [If yes, give war or dates of service]			
				17. INFORMANT Address Clement Y. Vaughan, Chesapeake City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute intestinal obstruction 174X							
DUE TO (b) Metastatic pelvic carcinoma 6 mos.							
DUE TO (c) Carcinoma of uterus 1 yr.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Urinary							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 1-19-59, to 1-23-59, that I last saw the deceased alive on 1-23-59, and that death occurred at 10:44 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Peter Stavrakis				ADDRESS (Street, city or town, state) 154 W. MAIN			
PHYSICIAN'S NAME (Type) PETER STAVRAKIS M.D.				DATE SIGNED 1-23-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/26/59		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Bethel, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks				ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR DATE JAN 28 59	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00508

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## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>13yrs. 11mo. 27days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <b>47X-3</b>	
f. STREET ADDRESS <b>928 Snows Court, N.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>EDWARD (NMI) GARNETT</b>		4. DATE OF DEATH Month Day Year <b>January 12 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 7, 1904</b>
9. AGE (In years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward Garnett, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Louisa Spriggs</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>Not available</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral, lower lobes</b> DUE TO <b>unresolved</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Granulocytic leukemia bone marrow acute</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>VA</b> 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days</b> <b>unknown</b>	
21. I certify that I attended the deceased from <b>January 16, 1945</b> to <b>January 13, 1958</b> and that death occurred at <b>4:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>V.A. Hospital, Perry Point, Md. 1-13-59</b>			
ACTUAL SIGNATURE <b>S. P. LACERVA</b>		PHYSICIAN'S NAME (Type) <b>Director, Professional Services</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>1/14/1959</b>		22b. DATE THEREOF <b>UNKNOWN</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Washington, D.C.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Sons</b>		ADDRESS <b>Harve de Grace, Md.</b>	
24a. REC'D BY REGISTRAR <b>JAN 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1911

NEW YORK

U. S.

NEW YORK

NEW YORK

NEW YORK

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00509

Reg. Dist. No.

520

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkmills</u> c. LENGTH OF STAY in 1b <u>all life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkmills</u> d. STREET ADDRESS _____		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>L</u> Last <u>Gregg</u>		4. DATE OF DEATH Month <u>1</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>8-19-1888</u>		9. AGE (in years last birthday) <u>70</u> yrs		10. IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS Hours _____ Mins _____	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Packer in Fiber Plant</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Fiber</u>		13. BIRTHPLACE (State or foreign country) <u>Cecil Co. Md.</u>	
14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		15. FATHER'S NAME <u>Frank Gregg</u>		16. MOTHER'S MAIDEN NAME <u>Annie Scarborough</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) _____		18. SOCIAL SECURITY NO. <u>217-09-3241</u>		19. INFORMANT <u>Miss Gregg, Elkmills, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> <u>p. m.</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____		20g. (County) _____		20h. (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>R. C. Dodson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1-15-59</u>	
EXAMINER'S NAME (Type) <u>R. C. Dodson</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/17/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sharps Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Fair Hill, Maryland</u>		22e. (State) _____		24a. REC'D BY REGISTRAR _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>		ADDRESS <u>Elkton, Md.</u>		24b. REGISTRAR'S SIGNATURE _____	
DATE <u>JAN 20 1959</u>		_____			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give flag 1, 2, and 3 to the funeral home or, if possible, to the funeral director. Give flag 4 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00510

521

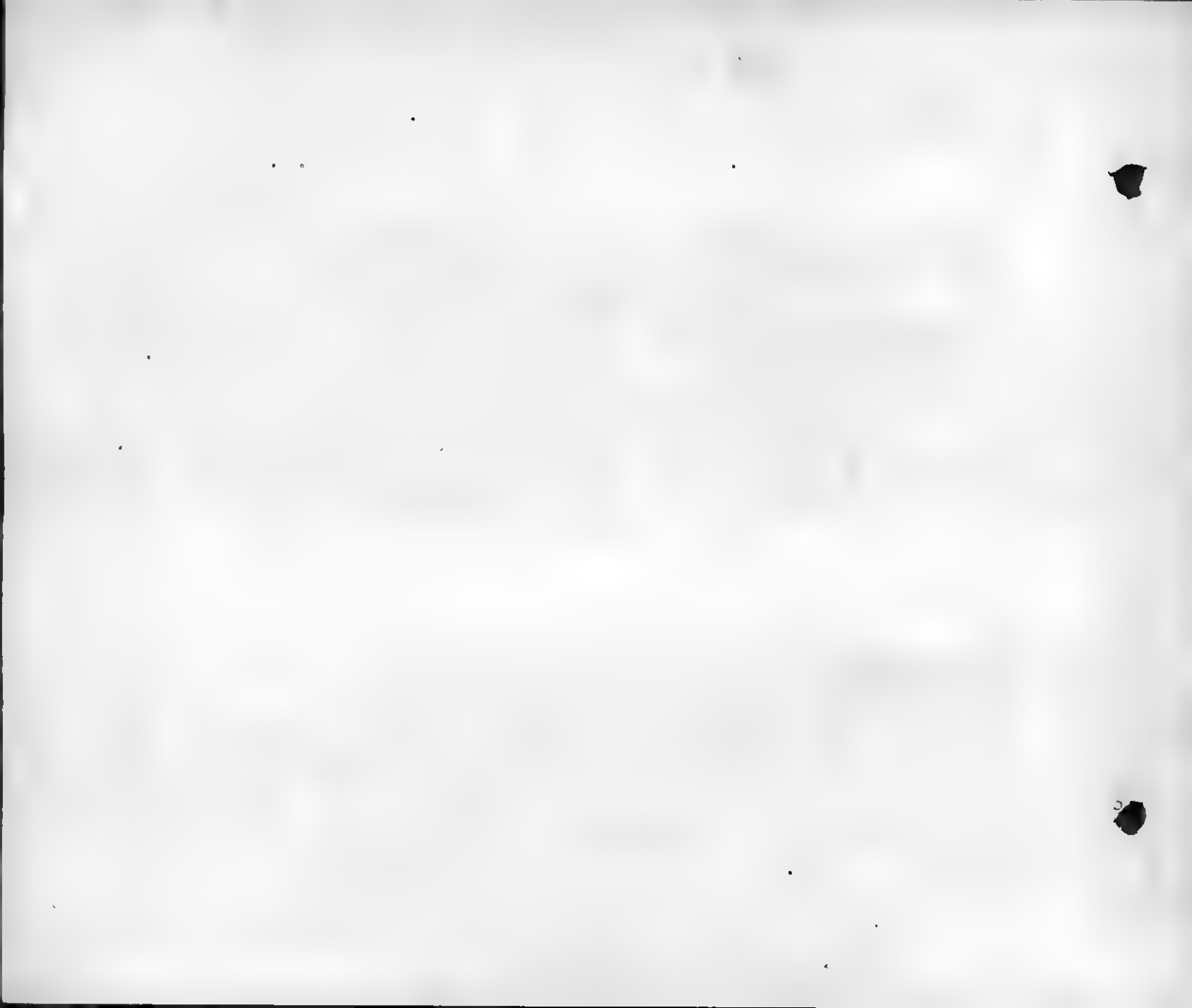
Reg. Dist. No

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Ma.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East R.D.</u>		c. LENGTH OF STAY IN 1b <u>25 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East R.D.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>T</u> Last <u>Grier</u>				4. DATE OF DEATH Month <u>1</u> Day <u>29</u> Year <u>19 59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-1-1901</u>		9. AGE (In years last birthday) <u>57</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Making Cabinets Delaware</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert T Grier</u>				14. MOTHER'S MAIDEN NAME <u>Ella Church side</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>218-05-544</u>		17. INFORMANT <u>Sara M. Grier, North East st. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>R. C. Dodson</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R. C. Dodson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>1-29-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Silver Brook</u>		22d. LOCATION (City, town, or county) (State) <u>Wilmington, Delaware</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Lunt</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 30 1959</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	





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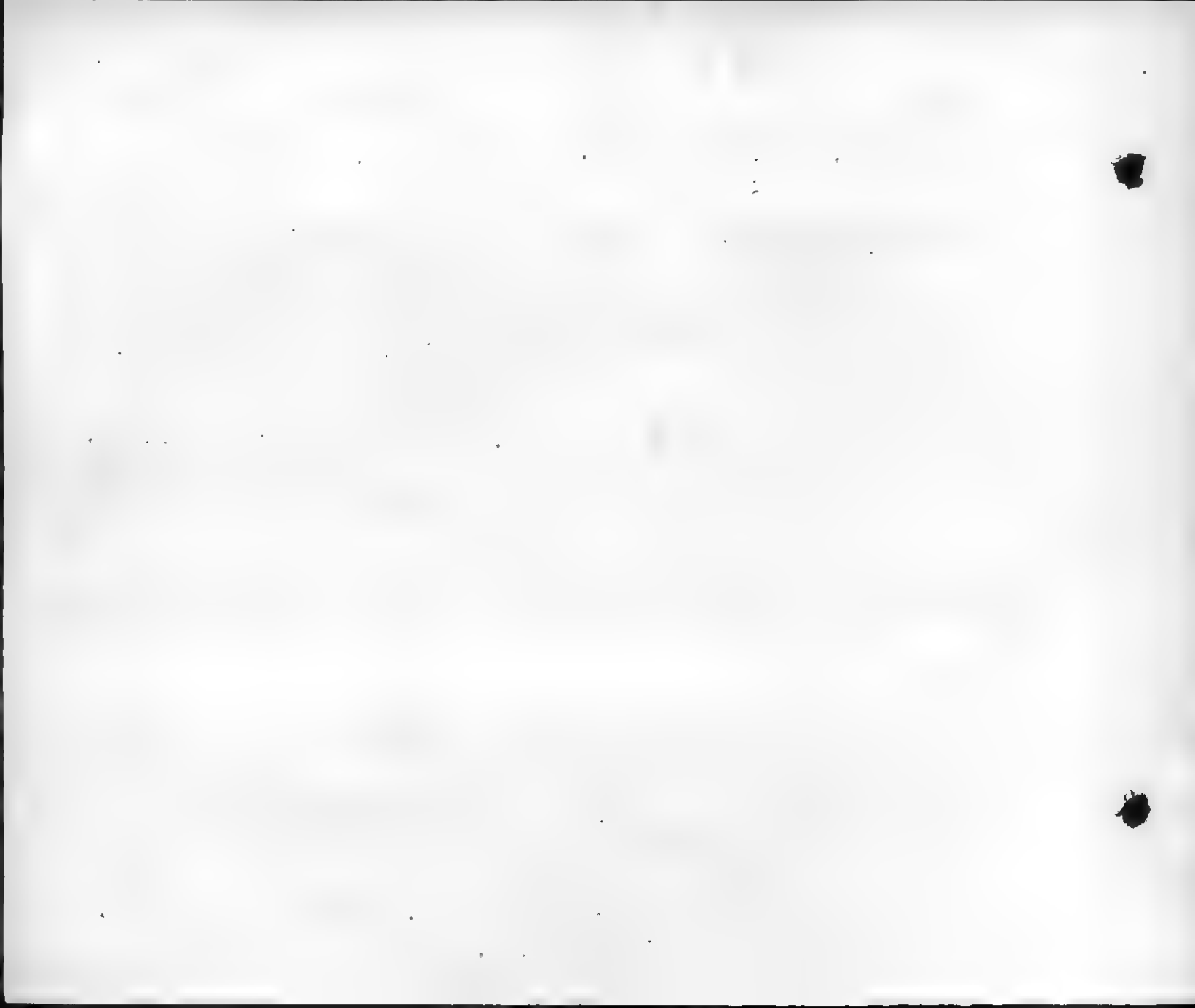
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <b>Cecil</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun, Rural</b>		c. LENGTH OF STAY IN lb <b>25 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun, Rural</b>	
3. NAME OF DECEASED (Type or print) <b>David Lewis Hall</b>		4. DATE OF DEATH <b>1 / 21</b> 19 <b>59</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4 / 12 / 1884</b>
9. AGE (in years last birthday) yrs <b>74</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Bayview, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Edward Hall</b>		14. MOTHER'S MAIDEN NAME <b>Susan Rebecca Davidson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
INFORMANT <b>Mrs. Florence Hamm Rising Sun, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro Vascular Accident</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <b>Arteriosclerosis</b> (c) <b>Hypertensive Cerebro Vascular Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>10 yrs</b> <b>10 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 10</b> , 19 <b>47</b> , to <b>Jan 21</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>January 20</b> , 19 <b>59</b> , and that death occurred at <b>11 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>1310 Post St, Md 1-21-59</b> ACTUAL SIGNATURE <b>W. H. Richardson</b> M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/25/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>West Nottingham Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Colora Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas E. McMullen</b>		24a. REC'D BY REGISTRAR <b>JAN 26 '59</b>	
ADDRESS <b>Rising Sun, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kram</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

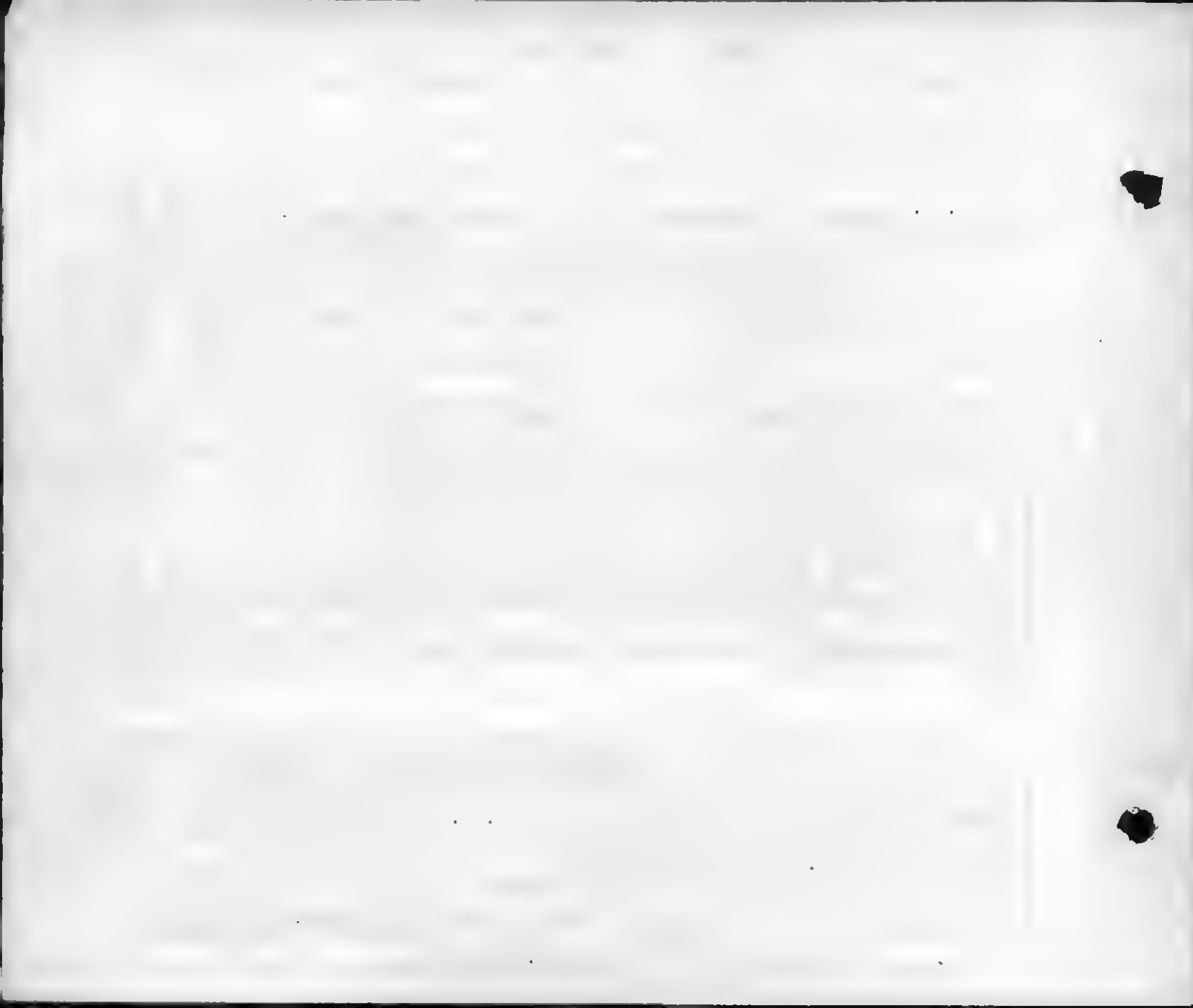
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## CERTIFICATE OF DEATH

Reg. Dist. No. 97

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bainbridge</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bainbridge</b>			
c. LENGTH OF STAY IN 1b <b>1 day</b>				d. STREET ADDRESS <b>Bainbridge Village, Trailer #77</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Gail Ann Henline</b>				4. DATE OF DEATH Month Day Year <b>January 7 1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 January 1959</b>		9. AGE (In years last birthday) yrs <b>13 10</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Jackie Ray Henline</b>				14. MOTHER'S MAIDEN NAME <b>Marilene Frances Foos</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. -----		17. INFORMANT <b>Hospital Record</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PREMATURITY</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>6 January 1959</b> to <b>7 January 1959</b> , that I last saw the deceased alive on <b>7 January 1959</b> , and that death occurred at <b>0130A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U. S. Naval Hospital, Bainbridge, Md 1/7/59</b>							
ACTUAL SIGNATURE <b>James K. Fugate</b>				M.D. <b>U. S. Naval Hospital, Bainbridge, Md 1/7/59</b>			
PHYSICIAN'S NAME (Type) <b>JAMES K. FUGATE, LT MC USNR</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/8/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>West Nottingham Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colora Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LEE A. PATTERSON &amp; SON</b>				ADDRESS <b>PERRYVILLE, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 8 1959</b>	
				24b. REGISTRAR'S SIGNATURE <b>Clifford S. ...</b>			





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## CERTIFICATE OF DEATH

Reg. Dist. No. 97

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bainbridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bainbridge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>U. S. Naval Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gay</u> Middle <u>Marie</u> Last <u>Henline</u>		4. DATE OF DEATH Month <u>January</u> Day <u>7</u> Year <u>1959</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6 January 1959</u>
9. AGE (In years last birthday) yrs. <u>1</u> Months <u>1</u> Days <u>1</u> Min. <u>15</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----	
10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		13. FATHER'S NAME <u>Jackie Ray Henline</u>	
14. MOTHER'S MAIDEN NAME <u>Marilene Frances Foos</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) -----	
16. SOCIAL SECURITY NO -----		17. INFORMANT <u>Hospital Record</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>6 January</u> , 19 <u>59</u> , to <u>7 January</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7 January</u> , 19 <u>59</u> , and that death occurred at <u>1350 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Allen P. Hartman</u> M.D.	U. S. Naval Hospital, Bainbridge, Md. 1/7/59
PHYSICIAN'S NAME (Type) <u>ALLEN P. HARTMAN, LT MC USNR</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/8/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Colona Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 9 '59</u>	24b. REGISTRAR'S SIGNATURE <u>S. Frank</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 48 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

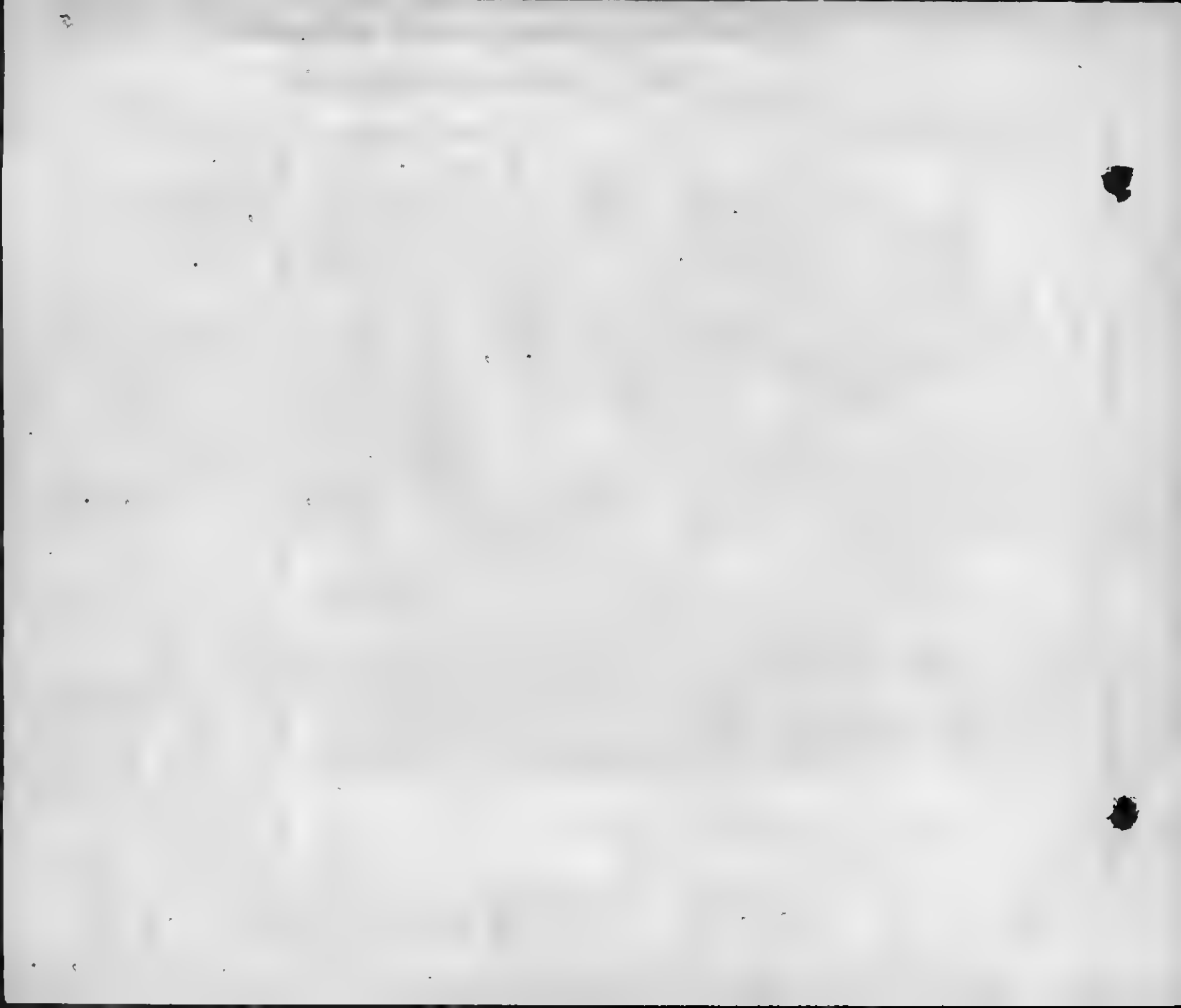
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00514

525 **CERTIFICATE OF DEATH**

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY Cecil		MARYLAND		STATE Md.		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Port Deposit, Rural		LENGTH OF STAY (In this place) Life		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Port Deposit, Rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Woodlawn Rd.				STREET ADDRESS (If rural give location) Woodlawn Rd.			
<b>3. NAME OF DECEASED</b> (Type or Print) Grover Cleveland Jackson				<b>4. DATE OF DEATH</b> (Month) 1 (Day) 20 (Year) 19 59			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, OR SEPARATED Married	8. DATE OF BIRTH Oct. 14, 1888	9. AGE last birthday 70 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY House		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Jackson				14. MOTHER'S MAIDEN NAME Jane Simmers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unk.) No		16. SOCIAL SECURITY NO. 220-09-2466		17. INFORMANT & ADDRESS Eva Jackson, Port Deposit, Md. RED			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
4. IMMEDIATE CAUSE (A) <i>Coronary Vascular Disease</i>						INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Hypertensive Coronary Vascular Disease</i>						5 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <i>Mottled Eruptions of face</i>						24 hrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> M. of work et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12-18-1954, to 1-20-1959, that I last saw the deceased alive on 1-20-1959, and that death occurred at 5:30 AM, from the causes and on the date stated above.							
SIGNATURE <i>W. H. Richards</i>				ADDRESS (Street, city, town, state) <i>Port Deposit, Md.</i>		DATE SIGNED <i>1-21-59</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1-23, 1959		NAME OF CEMETERY OR CREMATORY Asbury Cemetery		LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <i>W. A. Patterson &amp; Son</i>		ADDRESS Perryville, Md.	



526

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NORTH EAST RURAL</b>		c. LENGTH OF STAY IN 1b <b>16 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		d. STREET ADDRESS —	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Titus</b> Middle <b>Kataja</b> Last <b>Kataja</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>2</b> Year <b>1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 10, 1890</b>
9. AGE (In years last birthday) <b>68 yrs.</b>		IF UNDER 1 YEAR Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min. <b>68</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chicken Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM OWNER</b>	
11. BIRTHPLACE (State or foreign country) <b>FINLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA naturalized 5-12-1916</b>	
13. FATHER'S NAME <b>no information</b>		14. MOTHER'S MAIDEN NAME <b>no information</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>470-10-2891</b>	
17. INFORMANT <b>Mrs Helmi Kataja</b>		Address <b>North East Rd 1 Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Arteriosclerotic cardiovascular disease</b> years (c) <b>Generalized arteriosclerosis</b> years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension, Pulmona r t Emphysema, Bronchiectasis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Aug. 7</b> 19 <b>58</b> , to <b>Jan. 2</b> 19 <b>58</b> , that I last saw the deceased alive on <b>Aug. 7</b> 19 <b>58</b> , and that death occurred at <b>4:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Luis M. Cuza, M.D.</b>			
PHYSICIAN'S NAME (Type) <b>Luis M. Cuza, M.D.</b> <b>North East, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>	22b. DATE THEREOF <b>1-5-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Silverbrook Crematory</b>	22d. LOCATION (City, town, or county) (State) <b>Wilmington, New Castle, Delaware</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph P. Grant</b>		24a. REC'D BY REGISTRAR DATE: <b>1-5-59</b>	
ADDRESS <b>North East, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar or to burial, cremation, or removal, and in any event within 72 hours after death.





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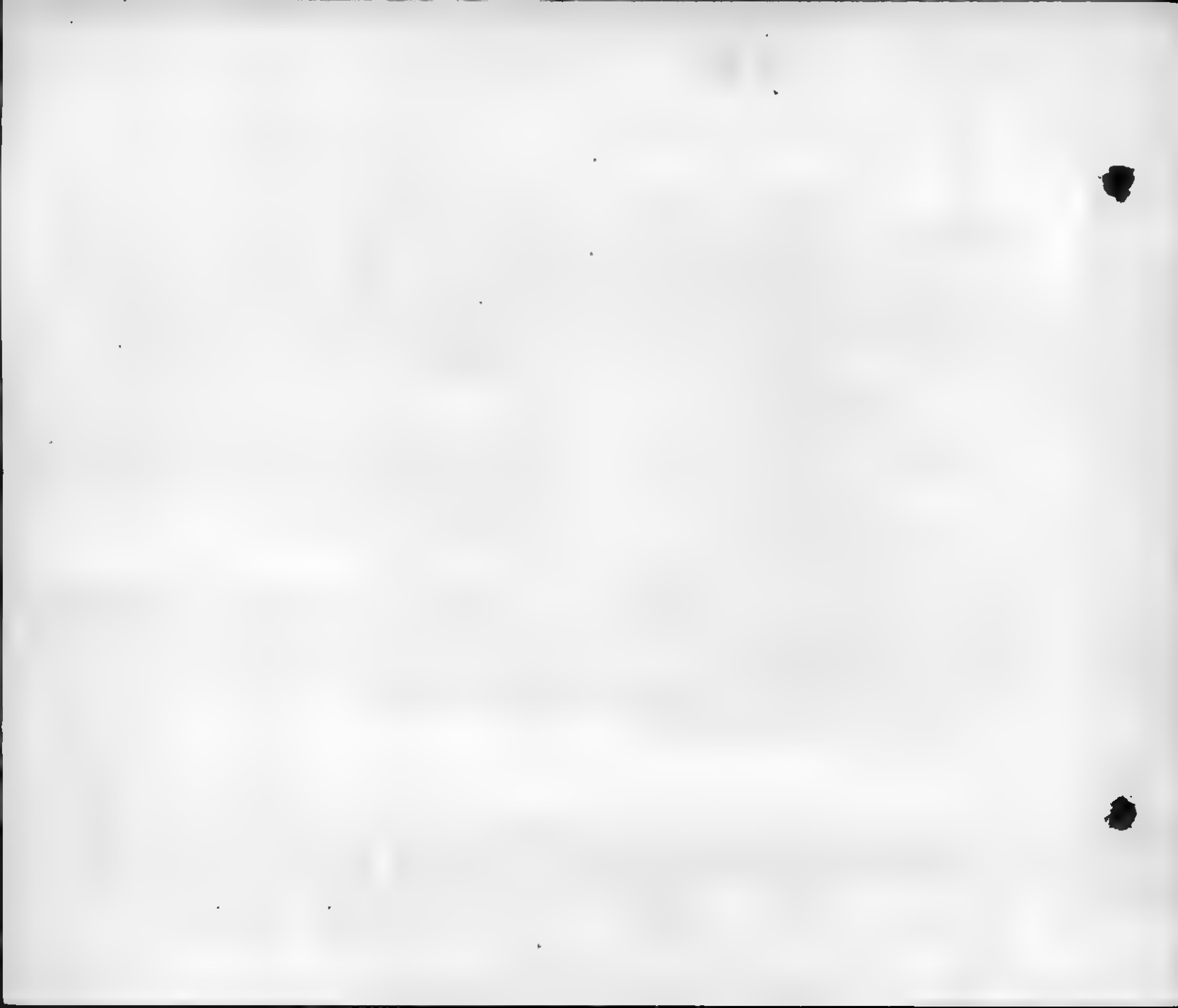
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institutional Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 11 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last Lawrence J. Kieffer				4. DATE OF DEATH Month Day Year Jan. 8 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12, 1894	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edwin Kieffer				14. MOTHER'S MAIDEN NAME Regina Loflin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Yes		16. SOCIAL SECURITY NO. 1111		17. INFORMANT Mrs. Beatrice P. Kieffer, Elkton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung, right 165X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) and Metastatic disease of liver. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH March-1958	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1958, to Jan. 8, 1959, that I last saw the deceased alive on Jan. 7, 1959, and that death occurred at 7 a. m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Elkton, Md. Jan. 9-1959							
ACTUAL SIGNATURE Theford H. Sprecher		PHYSICIAN'S NAME (Type) Wilford H. Sprecher, M.D. Elkton, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/11/59		22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memorial Park, Elkton, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Lepth E. Hicks				ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR DATE JAN 15 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Knaus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 Item 1 Filed 1-21-59 et  
 513  
 CERTIFICATE OF DEATH

00517

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION "At home"		d. STREET ADDRESS 219 W. High Street	
3. NAME OF DECEASED (Type or print) First Middle Last Florence C. Kirk		4. DATE OF DEATH January 11 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1932
9. AGE (In years last birthday) 76		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Cooke		14. MOTHER'S MAIDEN NAME Margaret Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 214-03-0341	
17. INFORMANT Mrs. Margaret Boyd, Elkton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Massive Myocardial Infarct Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) In farct (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 1/2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1953 to Jan 11, 1959 that I last saw the deceased alive on Jan. 6, 1959, and that death occurred on Jan 11, 1959, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED Jan 11, 1959	
ACTUAL SIGNATURE Milford H. Sprecher M.D.		DATE SIGNED Jan 11, 1959	
PHYSICIAN'S NAME (Type) Milford H. Sprecher M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/14/59	22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery	22d. LOCATION (City, town, or county) (State) Bethel, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ralph E. Hicks Elkton, Md.		24a. REC'D BY REGISTRAR DATE JAN 16 '59	24b. REGISTRAR'S SIGNATURE





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00518

514

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Jocell</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Jocell</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN 1b <u>5 Weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>				d. STREET ADDRESS <u>123 West Main St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Dorothy</u> Last <u>Elkton</u>				4. DATE OF DEATH Month <u>1</u> Day <u>31</u> Year <u>1959</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 21 1900</u>			
9. AGE (In years last birthday) <u>58</u> yrs		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>James Herrnell</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Bartley</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-22-9047</u>		17. INFORMANT <u>Mrs. John Herrnell</u> Address <u>Jocell, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO <u>Maligant neoplasm of prostate</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prostate</u> DUE TO <u>of prostate</u> (c) <u>of prostate</u>								INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Long standing hypertension</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month <u>1</u> Day <u>31</u> Year <u>1959</u> Hour <u>11</u> a.m. <u>30</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>1957</u> to <u>1959</u> , that I last saw the deceased alive on <u>1/31</u> , 19 <u>59</u> , and that death occurred at <u>7:40</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>154 W. Main St. Elkton, Md.</u> DATE SIGNED <u>2-2-59</u>									
ACTUAL SIGNATURE <u>Peter S. Savaris</u> M.D.									
PHYSICIAN'S NAME (Type) <u>PETER S. SAVARIS</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/3/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Elkton Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Walter duBois Jr.</u> ADDRESS <u>Elkton, Md</u>				24a. REC'D BY REGISTRAR <u>Feb 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. S. Kraus</u>			

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1911

1911

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

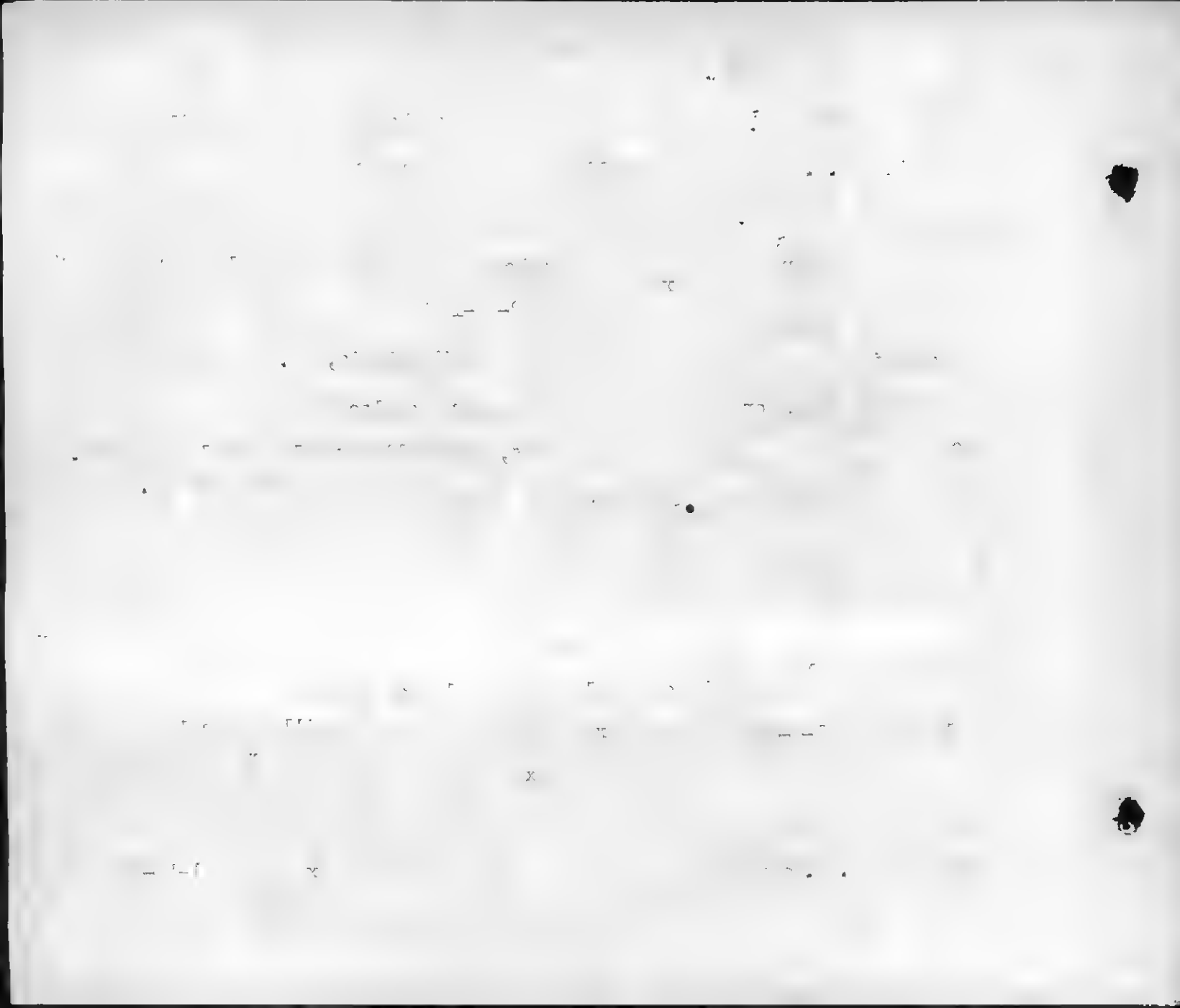
00519

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Earlville R.D.</b>		c. LENGTH OF STAY IN 1b <b>4 yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <b>Earlville</b>	
3. NAME OF DECEASED (Type or print) First <b>Ann</b> Middle <b>Malley</b> Last		4. DATE OF DEATH Month <b>1</b> Day <b>10</b> Year <b>19 59</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-27-1887</b>
9. AGE (in years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>10</b> Hours <b>19</b> Min <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Philadelphia, Pa.</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Robert Edmondson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Tomilson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Mrs. Mary Hollowaym</b>		Address <b>415 Drexel Court Apt. Drexel Hill Pa.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>9030 Exposure Freezing weather</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>9030</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Fell on the lawn and could not get up</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>11</b> a. m. <b>1-9-59</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b> (City or town) <b>Earlville</b> (County) <b>Cecil</b> (State) <b>MD</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>R. C. Dodson</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1-10-59</b>	
EXAMINER'S NAME (Type) <b>R. C. Dodson</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22a. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cem.</b>	
22b. DATE THEREOF <b>Jan 14 1959</b>		22c. LOCATION (City, town, or county) <b>Landdown Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Holloway Millington Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 15 59</b> 24b. REGISTRAR'S SIGNATURE <b>Christ S. Hance</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, on any event within 72 hours after death.



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

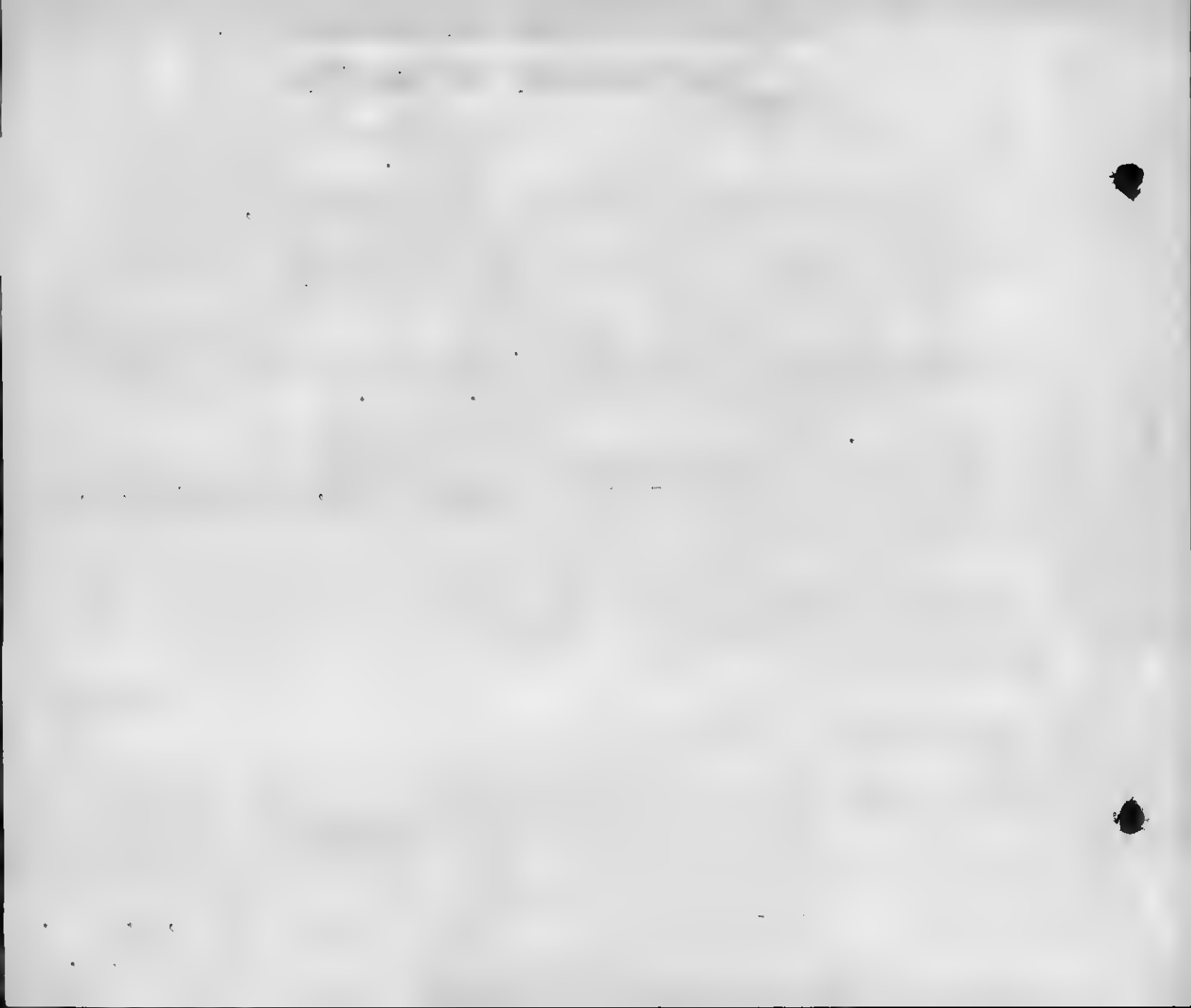
00520

528

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY Cecil		MARYLAND		STATE Md.		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN Port Deposit, Rural		LENGTH OF STAY (In this place) Life		CITY (If outside corporate limits, write RURAL end give nearest town) OR TOWN Port Deposit, Rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) Woodlawn			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) Mary		(Middle) Amelia		(Last) Meck		(Month) 1 (Day) 26 (Year) 1959	
<b>5. SEX</b> Female	<b>6. COLOR OR RACE</b> White	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> Single	<b>8. DATE OF BIRTH</b> Sept. 17, 1904		<b>9. AGE last birthday</b> 54 yrs.	<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Laborer			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> Fire Works Factory.		<b>11. BIRTHPLACE</b> (State or foreign country) Md.		<b>12. CITIZEN OF WHAT COUNTRY?</b> U S A
<b>13. FATHER'S NAME</b> Joseph D. Meck				<b>14. MOTHER'S MAIDEN NAME</b> Rhoda Barnes			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, No or unk.) No		<b>16. SOCIAL SECURITY NO.</b> 212-28-7757		<b>17. INFORMANT &amp; ADDRESS</b> Donald Meck, Port Deposit, Md. RFD			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>Cancer Cervix &amp; Metastasis</u>						INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>May</u> <u>1958</u> , <b>to</b> <u>Jan 26</u> <u>1959</u> , <b>that I last saw the deceased alive on</b> <u>Jan 26</u> <u>1959</u> , <b>and that death occurred at</b> <u>3:30</u> <u>P.M.</u> , <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>[Signature]</u>				<b>ADDRESS</b> (Street, City, town, state) <u>1214 E. 1st St. Port Deposit, Md.</u>		<b>DATE SIGNED</b> <u>10/20/59</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> Burial		<b>DATE THEREOF</b> 1-29-1959		<b>NAME OF CEMETERY OR CREMATORY</b> nopewell cemetery		<b>LOCATION</b> (City, town, or county) (State) Port Deposit, Md. R F D.	
<b>24. REC'D BY REGISTRAR</b> IAN 29 59		<b>REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Nell A. Patterson</u>		<b>ADDRESS</b> Perryville, Md.	
<b>DATE</b>							



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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>W. Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>			
c. LENGTH OF STAY IN 1b <u>10 yrs.</u>				d. STREET ADDRESS <u>George St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>George St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>NORRIS</u> Last <u>NORRIS</u>				4. DATE OF DEATH Month <u>JAN.</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 7 1870</u>	
9. AGE (In years last birthday) <u>88</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Church</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>112 11 3300</u>		17. INFORMANT <u>1100 Javin Chesapeake</u> Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF PROSTATE</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u> DUE TO (b) <u>  </u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>JUNE 15</u> , 19 <u>57</u> , to <u>DECEMBER 16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 15</u> , 19 <u>59</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry V Davis</u> M.D.				ADDRESS (Street, city or town, state) <u>Chesapeake City, Md.</u>			
DATE SIGNED <u>1/16/59</u>							
PHYSICIAN'S NAME (Type) <u>HENRY V DAVIS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/15/59</u>		<u>Bethel Cem</u>		<u>Bethel Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter du Boeuf</u>				ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 21 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>John E. Karna</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

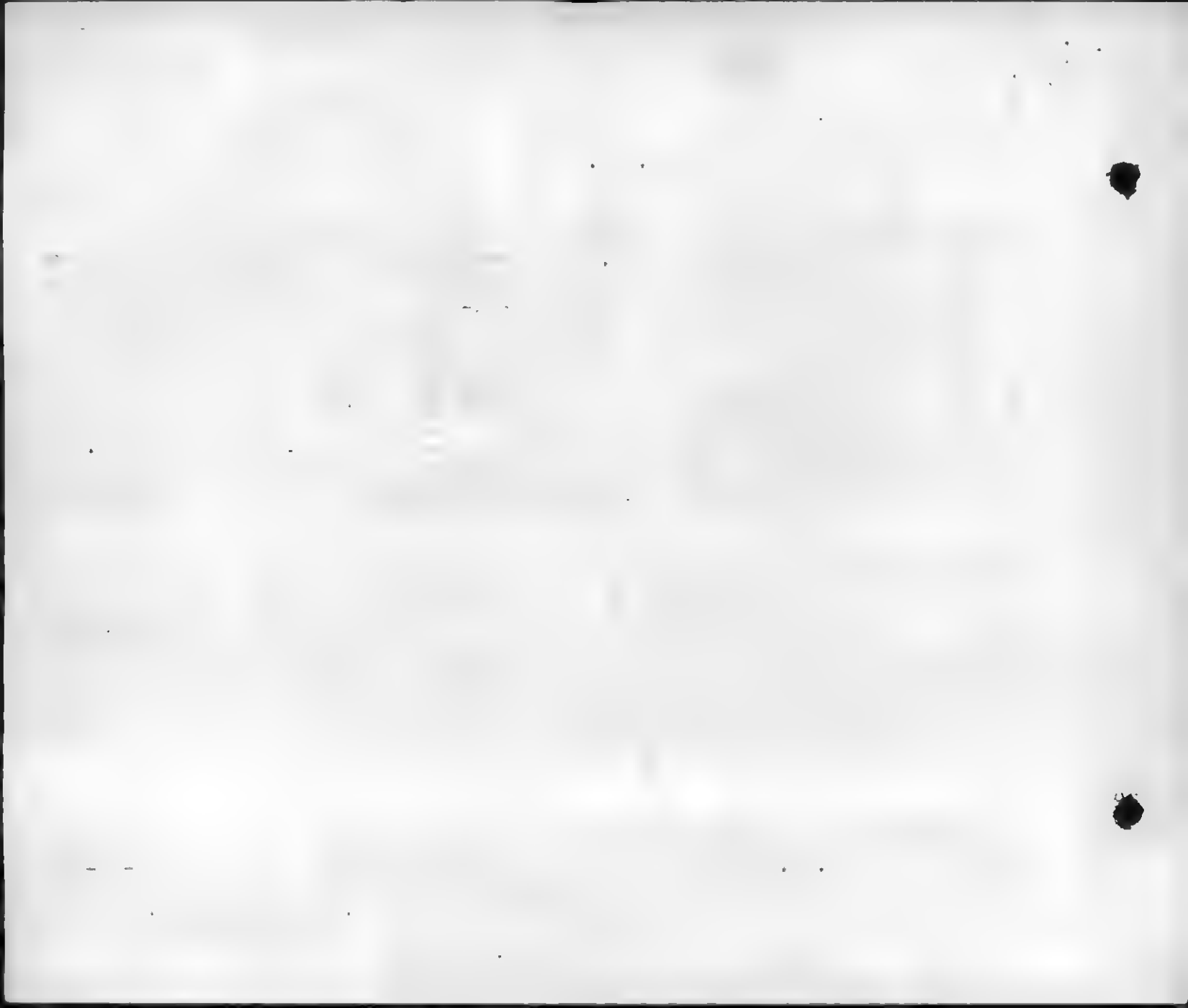
00522

Reg. Dist. No. 96

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>1</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>5yrs. 5mo. 22days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. STREET ADDRESS <b>3627 Eitemiller Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WALLACE</b> Middle <b>F.</b> Last <b>POWELL</b>		4. DATE OF DEATH Month <b>January</b> Day <b>15</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-24-23</b>
9. AGE (In years last birthday) <b>35</b> yrs.		10. IF UNDER 1 YEAR Months <b>35</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seaman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Merchant Marine</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Basil Powell</b>		14. MOTHER'S MAIDEN NAME <b>Florabell Herndon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes</b> <b>Korean Conflict</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>270.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour <b>0</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>R. C. DODSON</b>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1-15-59</b>	
EXAMINER'S NAME (Type) <b>R. C. DODSON</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>1/19/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Ft. Myer, Virginia.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PENNINGTON &amp; SON</b>		ADDRESS <b>Havre Degrace, Md.</b>	
24a. REC'D BY REGISTRAR <b>23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 531

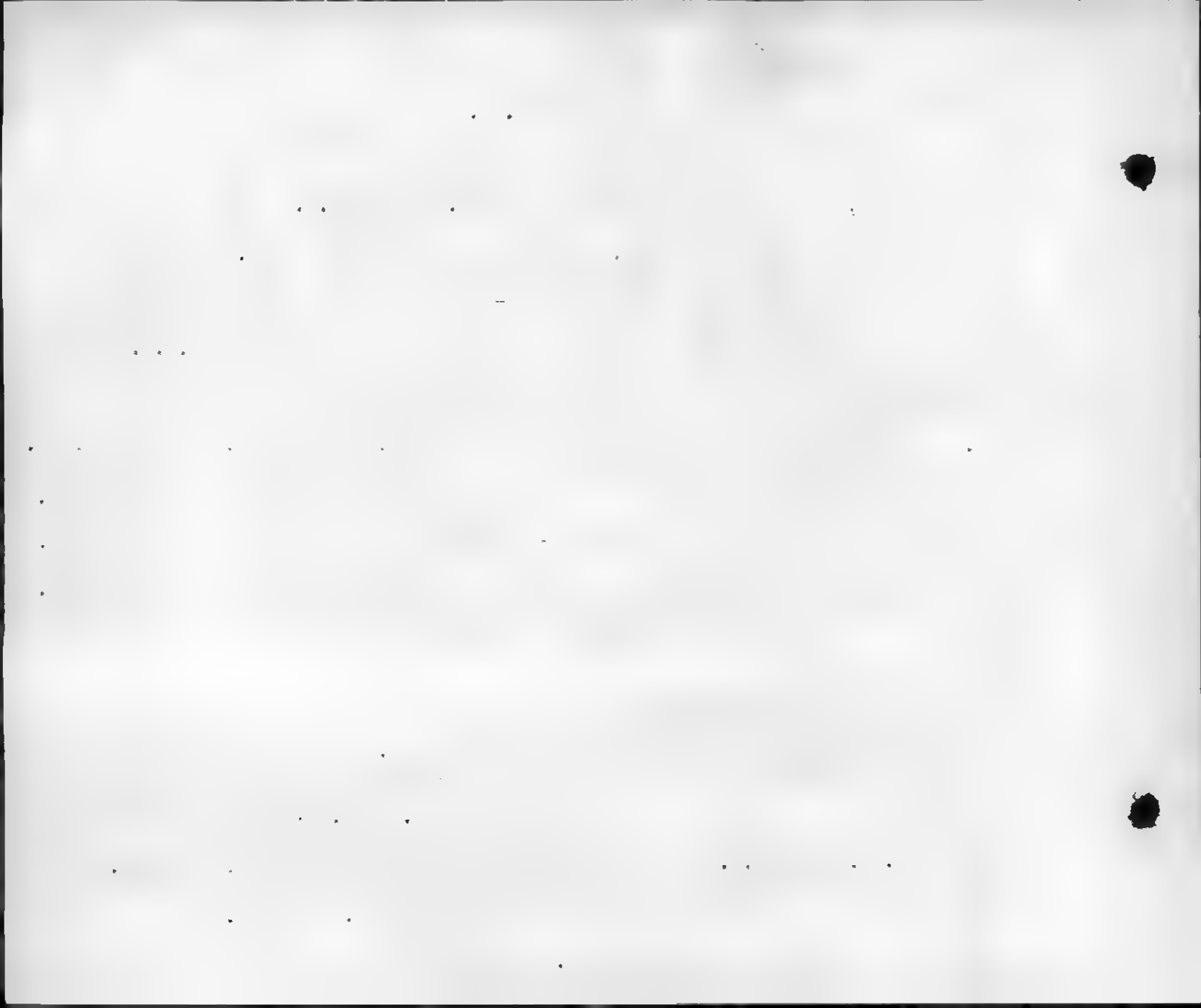
## CERTIFICATE OF DEATH

## 00523

Reg. Dist. No. 96

<b>1 PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u> c. LENGTH OF STAY IN 1b <u>3mos 14 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>VA Hospital, Perry Point, Maryland</u>				<b>2 USUAL RESIDENCE</b> (Where deceased lived If institut on Residence before admission) a. STATE <u>D. C.</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <span style="float: right;">47x.</span> d. STREET ADDRESS <u>2325 L. Street, N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>JAMES</u> Middle <u>A.</u> Last <u>PRILLAMAN</u>			<b>4. DATE OF DEATH</b> Month <u>Jan.</u> Day <u>2,</u> Year <u>19 59</u>				
<b>5 SEX</b> <u>Male</u>	<b>6 COLOR OR RACE</b> <u>Negro</u>	<b>7 MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>8-8-18</u>	<b>9. AGE</b> (In years last birthday) <u>40</u> yrs	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HRS.</b> Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Landscaper</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Unknown</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY.</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Wayland Prillaman</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Leathia Torrence</u>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unknown) (If yes, give year or dates of service) <u>Yes.</u> <u>WWII</u>		<b>16. SOCIAL SECURITY NO.</b> <u>579 05 0484</u>		<b>17. INFORMANT</b> Address <u>Hospital Records, VA Hospital, Perry Point, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Uremia</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Chronic glomerulo-nephritis</u> DUE TO (c) <u>Hypertensive cardia vascular disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Left ventricular hypertrophy and myocardial edema</u>						INTERVAL BETWEEN ONSET AND DEATH <u>over 5 yrs.</u>  <u>over 5 yrs.</u>  <u>over 5 yrs.</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. _____ p. m. <u>VA</u> <u>19</u>	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that</b> <del>K</del> attended the deceased from <u>Sept 18,</u> 19 <u>58,</u> to <u>Jan. 2,</u> 19 <u>59</u> <del>that I last saw the deceased</del> <del>XXXXXX</del> and that death occurred at <u>4:50P</u> M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>E. S. Ellis</u> M.D.			Acting Dir. Prof. Services,				
PHYSICIAN'S NAME (Type) <u>E. S. ELLS, M.D.</u>			<u>VA Hospital, Perry Point, Maryland.</u>				
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Removal</u>		<b>22b. DATE THEREOF</b> <u>1/6/1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National Cemetery Ft. Myer, Va.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>PENNIN TONER, SON</u>		ADDRESS <u>de Grace, Md.</u>		<b>24a. REC'D BY REGISTRAR</b> <b>24b. REGISTRAR'S SIGNATURE</b> <u>JAN 9 '59</u> <u>John P. Kane</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 532

## CERTIFICATE OF DEATH

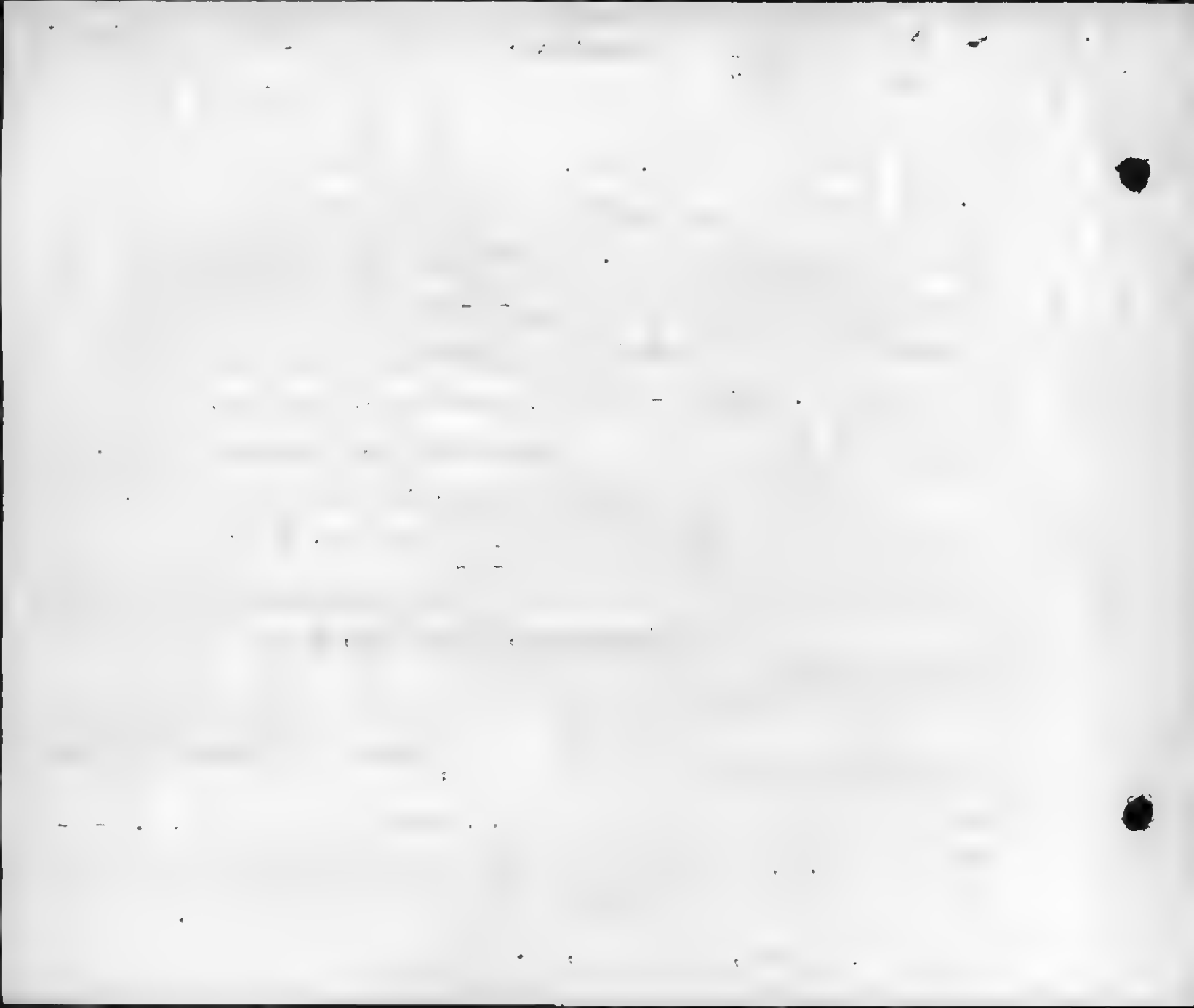
Reg. Dist. No. 96

00524

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admittance) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>3yrs. 7 mo.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> 1615			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <b>8905 Riggs Road</b>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>O.</b> Last <b>ROBINSON</b>				4. DATE OF DEATH Month <b>January</b> Day <b>21</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-30-88</b>		9. AGE (In years last birthday) <b>70 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>William J. Robinson -(deceased)</b>				14. MOTHER'S MAIDEN NAME <b>Laura Insley (deceased)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I</b>		17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia (following operation)</b> DUE TO <b>bilateral, unresolved</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <b>Gastroenterostomy, posterior for bleeding</b> DUE TO <b>duodenal ulcer 1-17-59</b> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, generalized, severe</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA 19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>June 22, 1955, to January 21, 1959</b> and that death occurred at <b>2:07 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>S. P. LACERVA</b> M.D. <b>V.A. Hospital, Perry Point, Md. 1-22-59</b>							
PHYSICIAN'S NAME (Type) <b>S. P. LACERVA</b>				Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>Jan 21/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Takoma Funeral Home, Takoma Park, Md.</b>				24a. REC'D BY REGISTRAR <b>JAN 26 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



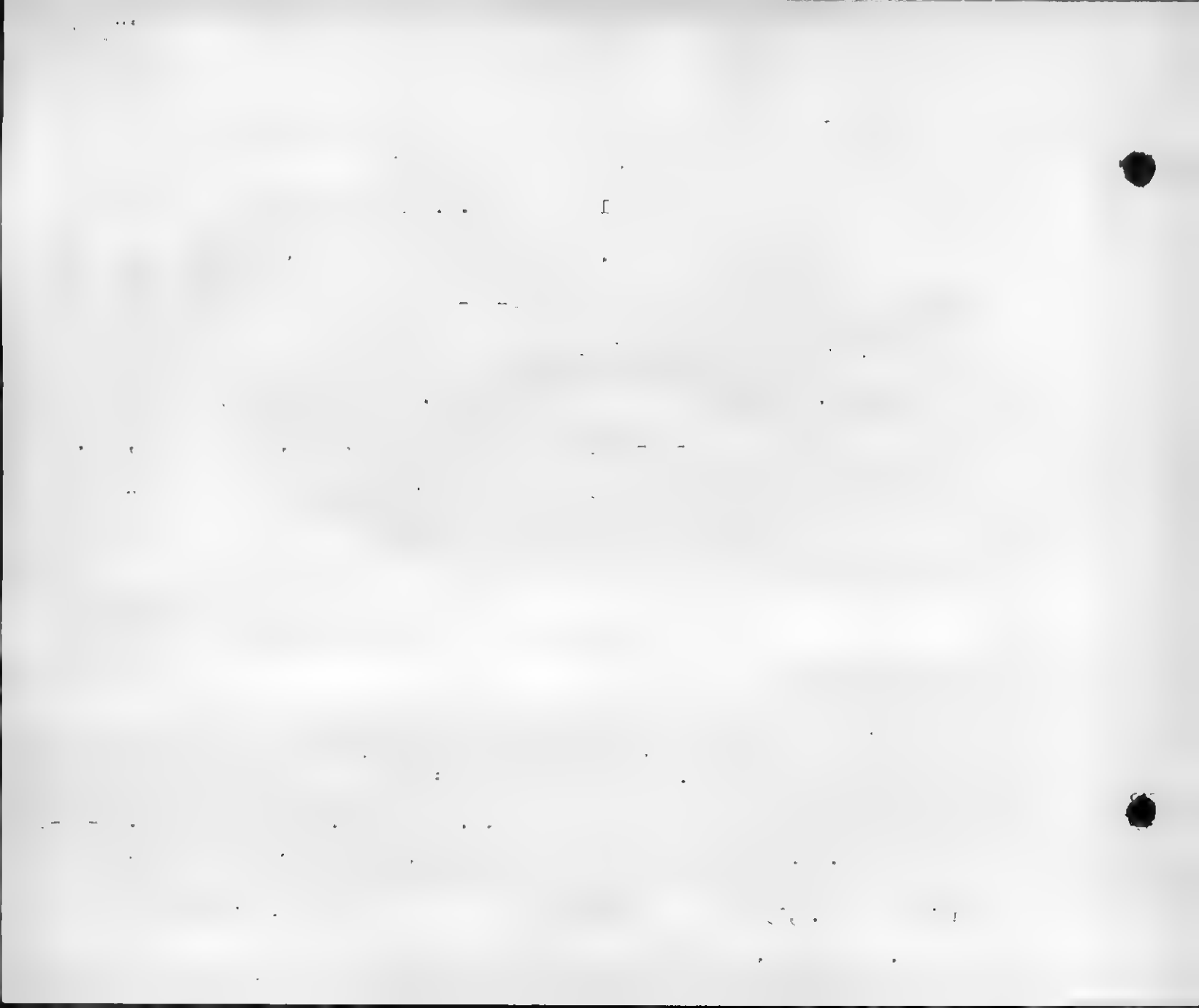
533

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1 PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>11 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE T. RUGGLES</b>		4. DATE OF DEATH Month Day Year <b>January 30 19 59</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-19-18</b>
9 AGE (In years last birthday) <b>40</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supply Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Army Chemical Center New York</b>	
11 BIRTHPLACE (State or foreign country) <b>USA</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John F. Ruggles</b>		14. MOTHER'S MAIDEN NAME <b>Helen M. Weir (deceased)</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes WW II</b>		16 SOCIAL SECURITY NO <b>140-05-8883</b>	
17. INFORMANT Address <b>Hospital Records, VAH, Perry Point, Md.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH <b>48-72 hours</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarction of the myocardium due to arteriosclerotic coronary thrombosis</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>Arteriosclerosis generalized moderate</b>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 19, 19 59, to January 30, 19 59</b> and that death occurred at <b>2:00 a.m.</b> from the causes and on the date stated above			
ACTUAL SIGNATURE <b>S. P. LACERVA</b>		DATE SIGNED <b>V.A. Hospital, Perry Point, Md. 1-30-59</b>	
PHYSICIAN'S NAME (Type) <b>S. P. LACERVA</b>		Director, Professional Services	
22a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 2, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cokesbury</b>	22d. LOCATION (City, town, or county) (State) <b>Abingdon, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOWARD K. MC COMAS, Abingdon, Maryland</b>		24a REC'D BY REGISTRAR <b>Feb 2 '59</b>	
24b REGISTRAR'S SIGNATURE <b>Howard K. McComas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2. The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2. The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2.





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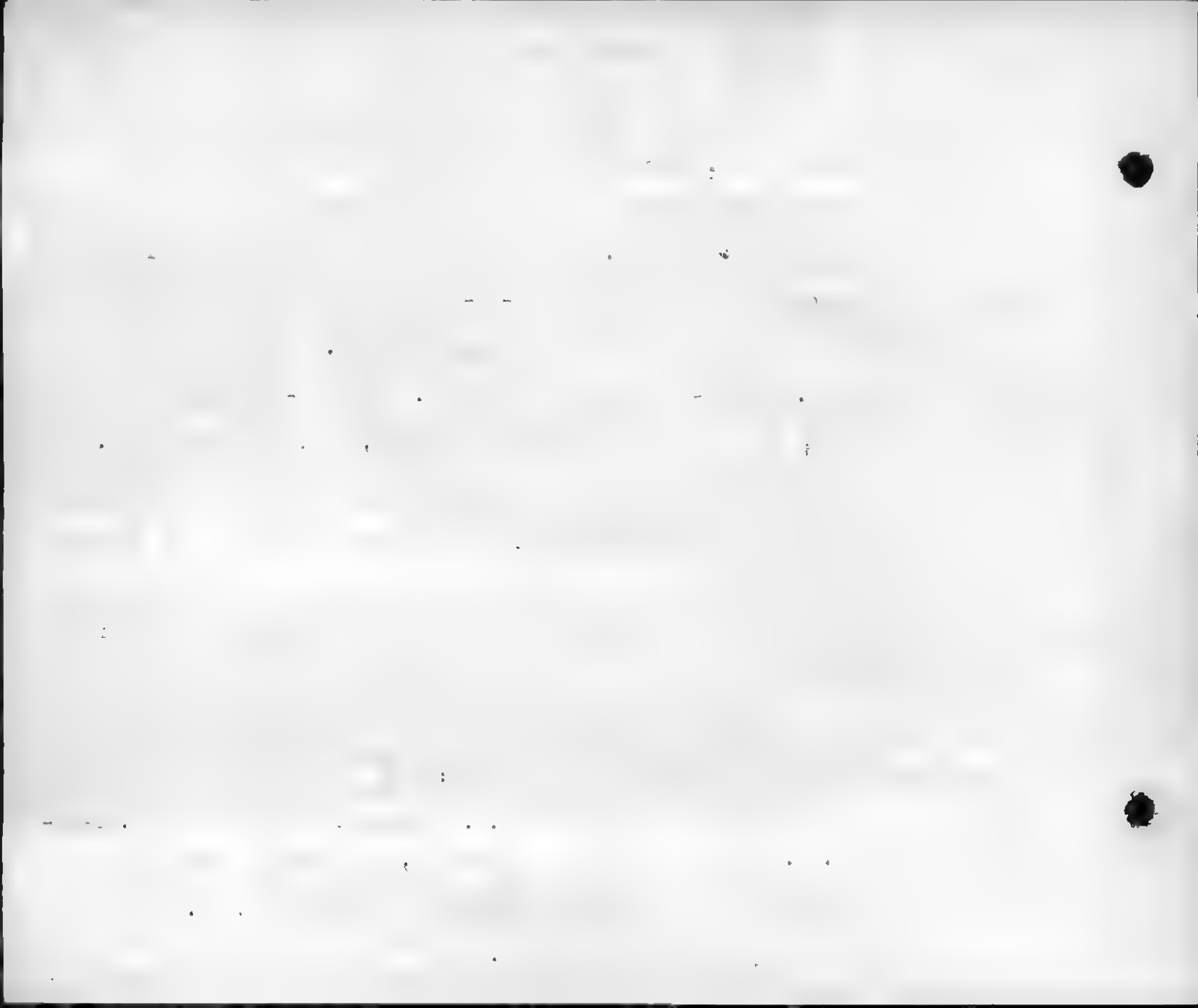
## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>7</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>11810 Ellington Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>W.</b> Last <b>SMITH</b>		4. DATE OF DEATH Month <b>January</b> Day <b>19</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-28-89</b>
9. AGE (In years last birthday) <b>69</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Coalsville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George W. Smith - Deceased</b>		14. MOTHER'S MAIDEN NAME <b>Laura V. Johnson - Deceased</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT Address <b>Hospital Records, VAH, Perry Point, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial fibrosis moderately severe</b> DUE TO <b>intraventricular septum</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease, severe</b> DUE TO (c) <b>unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 9, 19 58</b> , to <b>January 19, 19 59</b> and that death occurred at <b>1:50 PM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>1-20-59</b>			
ACTUAL SIGNATURE <b>S. P. LACERVA</b>		PHYSICIAN'S NAME (Type) <b>Director, Professional Services</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>1/21/59</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son, Havre de Grace, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>JAN 23 1959</b>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

535

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN 1b <u>LIFE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Goododds Farm RD4 Elkton Md.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Goododds Farm RD4</u>				e. STREET ADDRESS <u>Goododds Farm RD4</u>			
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>T.</u> Last <u>Taylor</u>				4. DATE OF DEATH Month <u>1</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 2, 1910</u>	9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William M.</u>				14. MOTHER'S MAIDEN NAME <u>Molly A. Fitzpatrick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. Helen Taylor</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolism</u> <u>100.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>carcinoma of colon</u> DUE TO (c) <u>retroperitoneal lymphocarcinoma</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>1 mo</u> <u>2 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>Nov. 16</u> , 19 <u>58</u> , to <u>Jan 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 3</u> , 19 <u>59</u> , and that death occurred at <u>3:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wallace M. Johnson</u> M.D.		ADDRESS (Street, city or town, state)			DATE SIGNED <u>1/6/59</u>		
PHYSICIAN'S NAME (Type) <u>WALLACE M. JOHNSON M.D.</u>		257 E. Main St Newark, Dola					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-7-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Ashland</u>		22d. LOCATION (City, town, or county) (State) <u>Ashland Delaware</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Pippin Funeral Home</u>		ADDRESS <u>W. H. Pippin, Elkton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 8 '59</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Pippin</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

515

Item 1 Film C238 2-2-59 et

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours thereafter.

VS A15ME  
BM 2/57

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before arrival on) a. STATE <b>Del.</b>		b. COUNTY <b>New Castle</b>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY <b>D.O.A. no time</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wilmington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>		d. STREET ADDRESS <b>2214 Market St.</b>		e. RESIDED ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Jesse Dewitt Thomas</b>		4. DATE OF DEATH Month <b>1</b> Day <b>18</b> Year <b>1959</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>2-8-1907</b>	9. AGE (In years last birthday) <b>51</b> yrs.	IF UNDER 1 YEAR Months <b>1</b> Days <b>18</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dyer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fabrics</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>	
13. FATHER'S NAME <b>Arthur Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Jane Moore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>yes W.W.2</b>		16. SOCIAL SECURITY NO. <b>222-10-2247</b>		17. INFORMANT <b>Ronald Thomas, Rodnet St, Wilmington, Del.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured Skull also right femur and both maxillary Laceration of face and right ankle.</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Hit car hit concrete bridge</b>			
20c. TIME OF INJURY Month, Day, Year <b>12-45 a.m. 1-18-59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 279</b>	
20f. (City or town) <b>Elkton</b>		20g. (County) <b>Cecil</b>		20h. (State) <b>Wd.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>R.C. Dodson</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>1-18-59</b>	
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>1-21-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gracelawn Memorial Park Wilmington, Delaware</b>	
22d. ADDRESS <b>Elkton, Maryland</b>		24a. REC'D BY REGISTRAR <b>JAN 23 59</b>		24b. REGISTRAR'S SIGNATURE <b>W. S. Thomas</b>	

1. The first part of the report is a general  
description of the project and its objectives.

2. The second part of the report is a detailed  
description of the methodology used in the study.

3. The third part of the report is a detailed  
description of the results of the study.

4. The fourth part of the report is a detailed  
description of the conclusions of the study.

5. The fifth part of the report is a detailed  
description of the recommendations of the study.

6. The sixth part of the report is a detailed  
description of the limitations of the study.

7. The seventh part of the report is a detailed  
description of the future research needs.

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN TB <b>34 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. STREET ADDRESS <b>12312</b>	
3. NAME OF DECEASED (Type or print) First <b>George C.</b> Middle <b>Travers</b> Last		4. DATE OF DEATH Month <b>January</b> Day <b>11</b> , Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-2-83</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Not Ascertainable</b>	
11. BIRTHPLACE (State or foreign country) <b>Aberdeen, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John W. Travers (D)</b>		14. MOTHER'S MAIDEN NAME <b>Emma Creswell (D)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>WW I</b>	
17. INFORMANT <b>Hospital Records VA Hospital, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis with posterior myocardial infarction</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Pulmonary emphysema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4220</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 wks</b> <b>Past 10 yrs</b> <b>3 or 4 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary infarction right side</b>		19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA 12-9 58 1-11 59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-9 58</b> to <b>1-11 59</b> and that death occurred at <b>11:20 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>VA Hospital, Perry Point, Md.</b> DATE SIGNED <b>1-11-59</b>	
ACTUAL SIGNATURE <b>W. M. Harris</b> M.D.		PHYSICIAN'S NAME (Type) <b>W. M. Harris, M.D. Acting Director, Professional Services</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL 1/15/59</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Baker's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Aberdeen, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Harris</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 19 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

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1917

State of New York, County of ...

On the ... day of ... 1917, at the City of ...

I, the undersigned, a duly qualified ...

do hereby certify that ...

... died on the ... day of ... 1917, at the City of ...

... at the age of ... years, ...

... of the County of ... State of New York.

Witness my hand and the seal of my office this ... day of ... 1917.

Attest: ...

... Registrar of Deaths

... County of ... State of New York

...

...

...

...

...

...

...

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...

...

...



537

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>18yrs.5mo.22days</b> <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>1006 N. Calhoun</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>HENRY H. WILSON</b>				4. DATE OF DEATH Month Day Year <b>January 22 19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-17-95</b>	9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Wilson</b>				14. MOTHER'S MAIDEN NAME <b>Rachael Hutton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I unknown</b>		17. INFORMANT Address <b>Hospital Records, VAH, Perry Point, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Mitral valve insufficiency of, chronic</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>unknown</b>						INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 31</b> 19 <b>40</b> , to <b>January 22, 19 59</b> and that death occurred at <b>3:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>[Signature]</b> M.D. <b>V.A. Hospital, Perry Point, Md. 1-22-59</b>				PHYSICIAN'S NAME (Type) <b>S. P. LACERVA Director, Professional Services</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-26-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George E. Kelson</b> ADDRESS <b>1348 N. Calhoun St. Balto. Md.</b>				24a. REC'D BY REGISTRAR <b>Jan 22 59</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

11-11-32

laborer

cause of death

heart disease

place of death

date of death

signature

location